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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Jan/07/2014

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: Chronic Pain Management program x 80 Hrs

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation and Pain Medicine

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[ ] Upheld (Agree)
[X] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for a chronic pain management program x 80 Hrs is medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: This patient is a male with a date of injury of xx/xx/xx. On 11/18/14, a progress summary was submitted noting this patient had completed 9 out of 10 authorized sessions or 80 authorized hours, in a chronic pain management program. A request was made at that time for 80 additional hours. It was noted these additional hours would be focusing specifically on helping this patient internalize new coping skills, along with cognitive behavioral changes and perception of his pain and feeling that would carry him outside of the program and back into the outside world of work. It was noted that his initial BDI2 score was 47 and a subsequent test scored him at 32. His BAI score was initially 24 and a follow up test scored him at 18. It was noted his pain at baseline was 7/10 and at week 2 a recurrent evaluation revealed his pain was 4/10. Sleep duration was 4 hours at baseline and went up to 6 hours at week 2. On 11/25/14, a request for reconsideration was submitted requesting preauthorization approval for the additional 80 hours of a chronic pain management program.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: On 11/20/14, a utilization review determination stated the requested additional 80 hours were non-certified. It was noted that there was inadequate documentation of demonstrated efficacy as documented by subjective and objective gains and the recommendation was for non-approval of the request. On 12/08/14, an appeal determination also stated the request was non-certified. It noted that documentation that the patient was willing to change had not been provided and there was no evidence of attempts to return the patient to modified work duties or full work status prior to the current request. There was no written job verification from the employer to return to work and the current request was not consistent with evidence based guidelines and the request was non-certified. The records provided for this review include the treatment plan with 11/18/14 progress summary. That treatment plan indicates that at baseline, the patient had

pain rated at 7/10 and was down to 4/10 currently. His GAF was 60 at baseline and went up to 70. Sleep duration was 4 hours at baseline and went up to 6 hours. Guidelines indicate that treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. Negative predictors of success should be identified and if present, they should be addressed. There should be documentation that the patient has motivation to change and is willing to change their medication regimen and total treatment duration should generally not exceed 4 weeks or 20 full days or 160 hours. The progress note indicated this patient has continued to exhibit interest and commitment to the program and that he has made good progress. He is also able to perform more self-management to attempt to manage his pain with at least 3-5 constructive alternative or coping skills before taking any medication. Therefore, there is subjective and objective evidence of gain with the previous 80 hours. It is the opinion of this reviewer that the request for a chronic pain management program x 80 Hrs is medically necessary and the prior denials are overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)